DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/28/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		155251 B. WING			R-C			
NAME OF PROVIDER OR SUPPLIER			1 5	STREET ADDRESS, CITY, STATE, ZIP CODE		09/	24/2015	
	to the Little of the Lilling				2901 W 37TH AVE			
MILLER'S MERRY MANOR				HOBART, IN 46342				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFI	ıv	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG		CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR)		{F 0	000	0}			
	to the Investigation of Complaints IN00179470 and IN00179997 completed on August 19, 2015.							
	This visit was in conjunction with the Investig of Complaint IN00181441.							
	Complaint IN00179470- Corrected							
	Complaint IN0017999	97- Corrected						
	Survey date: September 24, 2015							
	Facility number: 000154 Provider number: 155251 AIM number: 100289680							
	Census bed type: SNF: 14							
	SNF/NF: 65							
	Total: 79							
	Census payor type: Medicare: 14 Medicaid: 56 Other: 9							
	Total: 79							
	Sample: 10							
	410 IAC 16.2-3.1 in re	FR Part 483, Subpart B and egard to the Post Survey egardingstion of Complaints						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER MILLER'S MERRY MANOR STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE HOBART, IN 46342 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [F 000] Continued From page 1 Quality review completed by 26143, on September 27, 2015. R-C 09/24/2015 STREET ADDRESS, CITY, STATE, ZIP CODE 2901 W 37TH AVE (PACH DEFICIENCY STATE, ZIP CODE 2901 W 37TH AVE (PACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) [EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) [F 000] Continued From page 1 Quality review completed by 26143, on September 27, 2015.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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MILLER'S MERRY MANOR (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (F 000) Continued From page 1 Quality review completed by 26143, on	NAME OF PE	ROVIDER OR SUPPLIER	155251		STREET ADDRESS, CITY, STATE, ZIP CODE	0	9/24/2015		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) [F 000] Continued From page 1 Quality review completed by 26143, on	MILLER'S	MERRY MANOR			2901 W 37TH AVE				
Quality review completed by 26143, on	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP		COMPLETION		
	{F 000}	Quality review comple	eted by 26143, on	{F 00	00}				